

# Sterilizations

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## What is sterilization? [Refer to WAC 388-531-1550(1)]

Sterilization is any medical procedure, treatment, or operation for the purpose of rendering a client permanently incapable of reproducing (this includes vasectomies).

**Note:** MAA does not reimburse for hysterectomies performed solely for the purpose of sterilization. Refer to page H15, Hysterectomies.

## When does MAA reimburse for sterilization?

[Refer to WAC 388-531-1550(2)]

MAA covers sterilization when all of the following apply:

- The client is at least 18 years of age at the time consent is signed;
- The client is a mentally competent individual;
- The client has **voluntarily** given informed consent (see page 1, Definitions) in accordance with all of the requirements defined under this Sterilizations section;
- At least 30 days, but not more than 180 days, have passed between the date the client gave informed consent and the date of the sterilization.

**Note:** MAA reimburses providers for sterilizations for managed care clients 18 through 20 years of age under the fee-for-service system.

## Why do I need a DSHS-approved consent form?

Federal regulations prohibit payment for sterilization procedures until a properly completed consent form is received. To comply with this requirement, surgeons, anesthesiologists and assistant surgeons must obtain a copy of a completed consent form to attach to their claim. **No other form will be accepted.** The consent form may be obtained from the physician who performs the sterilization. MAA will deny a claim for a sterilization procedure received without a consent form. MAA will either return or deny a claim with an incomplete or improperly completed consent form.

The claim and completed consent form are to be submitted to the:

**DIVISION OF PROGRAM SUPPORT  
PO BOX 9248  
OLYMPIA WA 98507-9248**

## **Consent Form Requirements:**

- ✓ The signatures and other information on the consent form must be legible.
- ✓ All blanks on the consent form must be completed except race, ethnicity, and interpreter's statement blanks.
- ✓ For sterilization of a client between 18 and 20 years of age, use the DSHS 13-364(x) Consent Form.

**Cross out age 21** in the following three placed on the form and write in **18**.

- *Consent to Sterilization* section, “**I am at least 21...**”
- *Statement of Person Obtaining Consent* section, “**To the best of my knowledge...is at least 21...**”
- *Physician’s Statement* section, “**To the best of my knowledge...is a least 21...**”

### **What if the physician who signs the consent form is not the physician who performs the sterilization?**

The physician identified in the “Consent to Sterilization” section of DSHS 13-364x must be the same physician who completes the “Physician’s Statement” section and performs the sterilization procedure. If the physician who signed the above referenced sections of the DSHS 13-364x Consent Form is not the physician performing the sterilization procedure, the client must sign and date a new Consent Form indicating the name of the physician performing the operation under the “Consent for Sterilization” section, at the time of the procedure. This amended consent must be attached to the initial DSHS 13-364(x) Consent Form before billing MAA. **Note: Both consent forms must be attached to each billing. The original consent must meet all of the consent requirements.**

### **Sample Completed Consent Forms:**

See page H5 for a **REGULAR** consent form, page H8/H9 for a **AMENDED** consent form, and page H11 for a **BLANK** consent form. The blank consent form may be photocopied for your use.

To obtain a Consent Form (DSHS 13-364(x)), write or fax your request to:

**DSHS Warehouse  
PO Box 45816  
Olympia, WA 98504-5816  
FAX (360) 664-0597**

## When does MAA waive the 30-day waiting period?

[WAC 388-531-1550(3)(4)]

MAA **does not require** the 30-day waiting period, **but does require** at least a 72-hour waiting period for sterilization in the following circumstances:

- At the time of premature delivery, the client gave consent at least 30 days before the expected date of delivery. The expected date of delivery must be documented on the consent form.
- For emergency abdominal surgery, the nature of the emergency must be described on the consent form.

MAA waives the 30-day consent waiting period for sterilization when the client requests that sterilization be performed at the time of delivery, **and** completes a sterilization consent form when one of the following circumstances apply:

- The client became eligible for Medical Assistance during the last month of pregnancy (“*NOT ELIGIBLE 30 DAYS BEFORE DELIVERY*”);
- The client did not obtain medical care until the last month of pregnancy (“*NO MEDICAL CARE 30 DAYS BEFORE DELIVERY*”); or
- The client was a substance abuser during pregnancy, but is not using alcohol or illegal drugs at the time of delivery. (“*NO SUBSTANCE ABUSE AT TIME OF DELIVERY*.”)

**The provider must note on the HCFA-1500 claim form in field 19 or on the backup documentation, which of the above waiver conditions has been met.** Required language is shown in parenthesis. Electronic billers must indicate this information in the *Comments* field.

## When does MAA not accept informed consent?

[Refer to WAC 388-531-1550(5)(6)]

MAA does not accept informed consent obtained when the client is in any of the following conditions:

- In labor or childbirth;
- Seeking to obtain or obtaining an abortion; or
- Under the influence of alcohol or other substances that affect the client’s state of awareness.

## **Additional Requirements for Sterilization of Mentally Incompetent or Institutionalized Clients**

MAA has certain additional consent requirements that the provider must meet before MAA reimburses sterilization of a mentally incompetent or institutionalized client. MAA requires both of the following:

- A court order; and
- A sterilization consent form signed by the legal guardian, sent to MAA.

## **Reimbursement for Sterilization**

MAA reimburses all attending providers for the sterilization procedure only when the provider submits an appropriate, completed DSHS-approved consent form with the claim for reimbursement. MAA reimburses after the procedure is completed.

MAA reimburses epidural anesthesia in excess of the six-hour limit for deliveries if sterilization procedures are performed in conjunction with or immediately following a delivery. MAA determines total billable units by:

- Adding the time for the sterilization procedure to the time for the delivery; and
- Determining the total billable units by adding together the delivery BAUs, the delivery time, and the sterilization time.
- The provider cannot bill separately for the BAUs for the sterilization procedure.

# **How to Complete the Sterilization Consent Form**

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**The following numbers correlate to those listed on the  
following sample of the Sterilization Consent Form.**

## **Consent to Sterilization**

- 1** Doctor or Clinic – May be different than performing doctor if another physician takes over.
- 2** Procedure – Type of sterilization or vasectomy
- 3** Birthday of Client (Month, Day, Year)
- 4** Client's Name
- 5** Doctor – Physician that performed surgery, has to be the same name as the physician who signs on bottom right (see #16 below).
- 6** Procedure – Type of sterilization or vasectomy
- 7** Signature – Client's signature and dated 30 days prior to surgery date

## **Statement of Person Obtaining Consent**

- 8** Name of Individual – Patient name
- 9** Procedure – Type of sterilization or vasectomy
- 10** Signature of person obtaining consent and dated
- 11** Facility – Clinic or office name
- 12** Address – Physical address of clinic or office, city, state and zip code

## **Physician's Statement**

- 13** Name: Individual to be sterilized – Client's name
- 14** Date: Sterilization Operation – Date of Service of sterilization
- 15** Specify type of operation – Name of procedure
- 16** Physician – Signature of doctor who performed the surgery and dated after, or not more than one week before, the surgery is performed and must be the same physician as #5 above. If not, the addendum consent form must be attached to original consent containing the client signature, date and name of doctor who performed the sterilization.



## CONSENT FORM

**NOTE:** Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds.

### • CONSENT TO STERILIZATION •

I have asked for and received information about sterilization from \_\_\_\_\_  
DOCTOR OR CLINIC

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Aid to Families with Dependent Children (AFDC) or Medicaid that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children, or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a \_\_\_\_\_ . The discomforts, risks, and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally funded programs.

I am at least 21 years of age and was born on \_\_\_\_\_. MONTH DAY YEAR  
I, \_\_\_\_\_, hereby consent of my own free will to be sterilized by \_\_\_\_\_ DOCTOR

by a method called \_\_\_\_\_. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services; or
- Employees of programs or projects funding by that department but only for determining if Federal laws were observed.

I have received a copy of this form. \_\_\_\_\_

SIGNATURE Date: \_\_\_\_\_ MONTH DAY YEAR

You are requested to supply the following information, but it is not required. **RACE AND ETHNICITY DESIGNATION (PLEASE CHECK):**

- American Indian or  Black (not of Hispanic origin)  
 Alaska Native  Hispanic  
 Asian or Pacific Islander  White (not of Hispanic origin)

### • INTERPRETER'S STATEMENT •

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also

read him/her the consent form in \_\_\_\_\_ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

INTERPRETER

DATE

### • STATEMENT OF PERSON OBTAINING CONSENT •

Before \_\_\_\_\_ signed the consent  
NAME OF INDIVIDUAL  
form, I explained to him/her the nature of the sterilization operation

### STATEMENT OF PERSON OBTAINING CONSENT (CONTINUED):

, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

Date: \_\_\_\_\_

SIGNATURE OF PERSON OBTAINING CONSENT

FACILITY

ADDRESS

### • PHYSICIAN'S STATEMENT •

Shortly before I performed a sterilization operation upon \_\_\_\_\_

NAME: INDIVIDUAL TO BE STERILIZED \_\_\_\_\_ on

DATE: STERILIZATION OPERATION \_\_\_\_\_, I explained to him/her the nature of the sterilization operation \_\_\_\_\_, the fact that

it is intended to be a final and irreversible procedure and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

### (INSTRUCTIONS FOR USE OF ALTERNATIVE FINAL PARAGRAPHS:

Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

1. At least thirty (30) days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

2. This sterilization was performed less than thirty (30) days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- Premature delivery  
Individual's expected date of delivery: \_\_\_\_\_  
 Emergency abdominal surgery (describe circumstances): \_\_\_\_\_

PHYSICIAN

DATE



## Ejemplo de forma de consentimiento

**AVISO: LA DECISION DE NO HACERSE LA CIRUGIA U OPERACION PARA LA ESTERILIZACION QUE USTED PUEDE TOMAR EN CUALQUIER MOMENTO, NO VA A RESULTAR EN LA REVOCACION O EL PATROCINADOS CON FONDOS FEDERALES**

### • CONSENTIMIENTO PARA LA ESTERILIZACION •

Yo he solicitado y recibido información sobre la esterilización de \_\_\_\_\_ (Médico o clínica). Cuando solicité la información inicialmente, me dijeron que la decisión de ser esterilizado(a) es completamente mía. Me dijeron que podía decidir no ser esterilizado(a) y que mi decisión no afectaría mi derecho en el futuro a recibir tratamiento o cuidado médico. No voy a perder ningún tipo de asistencia o beneficios de programas patrocinados con fondos federales, tales como A.F.D.C. o Medicaid que recibo actualmente o que pudiera recibir en el futuro. **ENTIENDO QUE LA ESTERILIZACION ES UNA OPERACION QUE SE CONSIDERA PERMANENTE Y CUYOS RESULTADOS SON IRREVERSIBLES. HE DECIDIDO QUE NO QUIERO QUEDAR EMBARAZADA, TENER HIJOS (MUJER) O PROCREARLOS (HOMBRE).**

Se me ha informado sobre los métodos anticonceptivos temporales disponibles que me podrían proporcionar y que me permitirían quedar embarazada o procrear hijos EN EL FUTURO. Yo he rechazado estas alternativas y he elegido ser esterilizado(a). Entiendo que seré esterilizado(a) por medio de una operación conocida como \_\_\_\_\_ . Me han explicado las molestias, riesgos y beneficios asociados con la operación. Han respondido satisfactoriamente a todas mis preguntas.

Entiendo que la operación no se realizará hasta que hayan pasado por lo menos treinta días desde la fecha en la que firme esta forma. Entiendo que puedo cambiar mi decisión en cualquier momento y que mi decisión de no ser esterilizado(a), en cualquier punto, no resultará en la retención de cualquier beneficio o servicio médico proporcionado a través de programas patrocinados con fondos del gobierno federal.

Tengo por lo menos 21 años de edad y naci el \_\_\_\_\_ (mes, día, año).  
Yo, \_\_\_\_\_, por medio de la presente doy mi consentimiento (permiso) libremente y por mi voluntad para ser esterilizado(a) por \_\_\_\_\_ a través de un método \_\_\_\_\_ llamado \_\_\_\_\_ . Mi consentimiento se vence 180 días después de la fecha en la que firme este documento.

También doy permiso para que se presente esta forma y otros documentos médicos sobre la operación a:

Representantes del Departamento de Salud y Servicios Sociales; o

A empleados de programas o proyectos patrocinados por ese Departamento, pero sólo para que puedan determinar si se han cumplido las leyes federales.

He recibido una copia de esta forma.

\_\_\_\_\_  
(firma)

Fecha: \_\_\_\_\_  
(mes, día, año)

Se le pide que proporcione la siguiente información pero no es obligatorio:

Definición de raza y origen étnico (por favor marcar el grupo apropiado)

- Indígena americano o indígena de Alaska
- Asiático o de las Islas del Pacífico
- Negro (de origen no hispano)
- Hispano
- Blanco (de origen no hispano)

### • DECLARACION DEL INTERPRETE •

Si se ha contratado a un intérprete para asistir al individuo que será esterilizado(a):

He traducido la información y los consejos que se han presentado verbalmente al individuo que desea ser esterilizado(a) por la persona que ha obtenido esta forma de consentimiento. También le he leído a él/ella la forma de consentimiento (permiso) en el idioma \_\_\_\_\_ y le he explicado su contenido. Según mi mejor entender, creo que él/ella ha entendido esta explicación.

(Intérprete)

(Fecha)

DHSS 13-364 (X) SP (REV. 03/1997)

### • DECLARACIÓN DE LA PERSONA QUE OBTIENE ESTA FORMA DE CONSENTIMIENTO •

Antes de que \_\_\_\_\_ (nombre del individuo) firmara esta forma de consentimiento (permiso), le expliqué a él/ella los detalles de la operación para la esterilización \_\_\_\_\_, el hecho que la intención del procedimiento es permanente e irreversible, y las molestias, riesgos y beneficios asociados con este procedimiento.

Le ofrecí información y asistencia al individuo que desea ser esterilizado(a) sobre la alternativa disponible metodos temporales de control de la natalidad. Le expliqué que la esterilización es diferente porque es permanente.

Le expliqué al individuo que desea esterilizarse que puede retirar su consentimiento en cualquier momento y que él/ella no perderá ningún servicio de salud o cualquier otro beneficio proporcionado con el patrocinio de fondos federales.

Según mi mejor entender, creo que el individuo que desea esterilizarse tiene por lo menos 21 años de edad y parece ser mentalmente competente. El/ella ha solicitado con conocimiento de causa y voluntariamente el ser esterilizado(a) y parece entender el procedimiento y las consecuencias del procedimiento.

(Firma de la persona que obtiene este consentimiento)

(Fecha)

(Establecimiento)

(Dirección)

### • DECLARACION DEL MEDICO •

Previamente a realizar la operación para la esterilización en \_\_\_\_\_

(Nombre del individuo que sera esterilizado(a)) (Fecha de la operación para la esterilización) expliqué a él/ella el procedimiento de la operación para la esterilización \_\_\_\_\_, el hecho que la intención del procedimiento es permanente e irreversible, y las molestias, riesgos y beneficios asociados con el procedimiento.

Le ofrecí al individuo que desea ser esterilizado(a) información y asistencia sobre la alternativa disponible de otros métodos temporales de control de la natalidad. Le expliqué que la esterilización es diferente porque es permanente.

Le expliqué al individuo que desea esterilizarse que puede retirar su consentimiento en cualquier momento y que él/ella no perderá ningún servicio de salud o cualquier otro beneficio proporcionado con el patrocinio de fondos federales.

Según mi mejor entender, creo que el individuo que desea esterilizarse tiene por lo menos 21 años de edad y parece ser mentalmente competente. El/ella ha solicitado con conocimiento de causa y voluntariamente el ser esterilizado(a) y parece entender el procedimiento y las consecuencias del procedimiento.

**(Instrucciones para el uso de los párrafos finales alternativos:** Use el primer párrafo que se presenta a continuación a excepción de los casos de parto prematuro y cirugía abdominal de emergencia durante los cuales se realizó la esterilización antes de los 30 días después de la fecha en la que el individuo firmó esta forma de consentimiento. En esos casos, se debe usar el segundo párrafo a continuación. Tache el párrafo que no use.)

(1) Han transcurrido por lo menos 30 días entre la fecha en la que el individuo firmó esta forma de consentimiento y la fecha en la que se realizó la esterilización.

(2) La operación para la esterilización se realizó menos de 30 días, pero más de 72 horas, después de que el individuo firmó esta forma de consentimiento debido a las siguientes circunstancias (marque la respuesta apropiada y escriba la información requerida):

- Parto prematuro  
Fecha en la que se esperaba el parto: \_\_\_\_\_
- Cirugía abdominal de emergencia (Describa las circunstancias): \_\_\_\_\_

(Médico)

I. Paciente

(Fecha)

**NOTA: TODOS LOS ESPACIOS EN BLANCO DEBEN SER LLENADOS,  
EXCEPTO COMO SE INDICA A CONTINUACION**

**Instrucciones para el paciente para llenar el formulario de consentimiento para esterilización**

1. En el primer espacio en blanco, escriba el nombre del médico o la clínica que le está proporcionando la información.
2. En el segundo espacio en blanco, escriba el nombre de la operación.
3. En el siguiente espacio en blanco, usted debe escribir el mes, día y el año en que nació.
4. Llene los últimos cinco espacios en blanco como se indica. Asegúrese de que el nombre del médico sea el nombre del médico que realmente efectuará la operación.
5. No se requiere que usted llene la sección de "Raza y origen étnico". Eso es opcional.

**Declaración del intérprete**

Esta sección del formulario debería ser llenada SOLAMENTE si se requiere interpretación a otro idioma.

**Declaración de la persona que está obteniendo el consentimiento**

Llene los dos primeros espacios en blanco con el nombre del paciente y el nombre del procedimiento que se va a efectuar.

2. Llene los cuatro últimos espacios en blanco con su firma, la fecha, su nombre, y la dirección de la institución.

**Declaración del médico**

1. Llene las tres primeras partes en blanco con el nombre del individuo que va a ser esterilizado, la fecha de la operación de esterilización, y el tipo específico de la operación.
2. Tache el "párrafo de alternativa final" si fuera inapropiado.
3. El médico que va a efectuar la operación tiene que firmar. La fecha que se indica debajo de la firma, debe ser ya sea la fecha de la esterilización o la fecha que sigue a la esterilización.
4. El nombre del médico que va a efectuar la operación tiene que figurar en la parte marcada *esterilizado por* en la sección de CONSENTIMIENTO PARA ESTERILIZACION.

**NOTICE: ALL BLANKS MUST BE COMPLETED EXCEPT AS INDICATED BELOW**

**Instructions to the Patient for Completing Consent to Sterilization**

1. In the first blank space, write the name of the doctor or clinic giving you the information.
2. In the second blank space, write the name of the operation.
3. In the next blank space, you must write the month, day, and year you were born.
4. Fill in the last five blanks as indicated. Be sure the doctor's name is the name of the physician who will actually perform the operation.
5. You are not required to fill out the "Race and Ethnicity" portion. It is optional.

**Interpreter's Statement**

This section of the form should be completed ONLY if interpretation into another language is required.

**Statement of Person Obtaining Consent**

1. Complete the first two blanks with the patient's name and the name of the procedure to be performed.
2. Fill in the last four blanks with your signature, date, name, and address of the facility.

**Physician's Statement**

1. Complete the first three blanks with the name of the individual to be sterilized, the date of the sterilization operation, and the specific type of operation.
2. Cross out the "alternative final paragraph" if inappropriate.
3. The performing surgeon must sign. The date given below the signature must either be the date of the sterilization or a date which follows the sterilization.
4. The performing surgeon's name must appear in the ***sterilized by*** blank in the CONSENT TO STERILIZATION section.

# **How to Complete the Amended Consent Form**

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The following numbers correlate to those listed on the sample Amended Consent Form.

## **Consent to Sterilization**

- 4** Client's name
- 5** Doctor or physician that performed surgery (same name as in 16).
- 7** Signature – Client's signature and current date.

## **Physician's Statement**

- 13** Name: Individual to be sterilized – Client's name
- 14** Date: Sterilization Operation – Date of Service of sterilization
- 15** Specify type of operation – Name of procedure
- 16** Physician – Signature of doctor who performed the surgery and dated after, or not more than one week before, the surgery is performed.

~~The next two pages are samples for:~~

Instances when the physician who performs the surgery is different from the physician who signed the original consent form.

**Original and amended consent forms  
must be stapled together and submitted with each claim.**